State of Maine

BOARD OF COMPLEMENTARY HEALTH CARE PROVIDERS

Certificate for Custom-made Chinese Herbal Formulations

You must be a licensed acupuncturist to hold this certificate. If you are not a licensed acupuncturist this application must accompany an acupuncturist application.

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8689 or Main Receptionist (207) 624-8603
TTY users call Maine relay 711
FAX (207) 624-8637
Web address: www.maine.gov/professionallicensing
Email: comphealth.lic@maine.gov

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35 STATE HOUSE STATION, AUGUSTA ME 04333 WEBSITE: WWW.MAINE.GOV/PROFESSIONALLICENSING

APPLICATION INSTRUCTIONS

CUSTOM-MADE CHINESE HERBAL FORMULATIONS CERTIFICATE

You must hold a valid Maine Acupuncture license to be eligible for this certification.

Information checklist for documents to be submitted to the Board in one package at time of application. (This is an abbreviated checklist and does not replace the requirements outlined in the Complementary Health Care Providers Laws and Rules. Please review them carefully for more detailed and clarifying information.)

Fax submissions of applications and supporting documentation will not be accepted.

ONE OF THE THREE METHODS DESCRIBED BELOW MAY BE USED TO ACHIEVE LICENSURE:

CUSTOM-MADE CHINESE HERBAL FORMULATIONS

You may apply for certification by using at least one of the following methods. Please refer to the law and board rules for more detailed information.

- □ Method 1 - NCCAOM Certification with Chinese Herbology; OR
- □ Method 2 - Master's Degree or Equivalent; OR
- □ Method 3 - Herb Certificate Training Program

□ **Completed Application**
Complete, sign the application and submit with the appropriate fees and documentation.

□ **Proof of age**
A copy of your official birth certificate or other official legal document is acceptable.

□ **Any other supporting documentation such as: verification of licensure or criminal conviction information**
Submit verification from every state in which you currently hold or have ever held any type of professional license (except Maine).

□ **Court judgment and decision** of any criminal conviction and a **written statement** regarding the crime.

The Board of Complementary Health Care Providers requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

PROCESSING TIME:

Your application has a greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the authority to administer will be issued and the status will show as ACTIVE.

Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

The application process must be complete within 90 days of submission or application and supporting materials will be invalid pursuant to Board Rule, Chapter 3, 1-B.

IMPORTANT INFORMATION REGARDING YOUR LICENSE: The Office no longer prints licenses. Upon issuance of your license, you will be notified by email using the email address you provide in this application from *noreply@maine.gov* that your license has been issued with your license attached to the email (a paper license will not be sent by regular mail). The email with your license will contain the access code that is required to renew your license online when the time comes. You may also update your contact information and email address using this access code, go online to www.maine.gov/professionallicensing.

Approximately sixty (60) days prior to the expiration of your license a courtesy renewal reminder will be sent to you by email. It is important that you maintain a current email on file or risk not receiving the renewal reminder. You do not need to wait for a renewal reminder to renew your license. The online renewal opens sixty (60) days prior to the license expiring and you may renew online anytime.

CONTINUING EDUCATION

As an Acupuncturist you will be required to satisfy the Continuing Education requirements identified in Chapter 5 of the Board's rules. Please be sure to review this chapter carefully.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address**: 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be e-mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) *or* credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)
FULL LEGAL NAME *FIRST* *MIDDLE INITIAL* *LAST*
ANY OTHER NAMES EVER USED:
DATE OF BIRTH *mm / dd / yyyy* SOCIAL SECURITY NUMBER - -
CONTACT ADDRESS
CITY STATE ZIP COUNTY
PHONE # ( ) FAX # ( ) E-MAIL (**Your license will be emailed)**

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime? (circle one) NO YES**
   If yes, enclose a detailed, signed description of what happened (including dates) and a copy of the court judgment.
2. **Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) NO YES**
   If yes, enclose a detailed, signed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

Board of Complementary Health Care Providers

Certification for Custom-Made Chinese Herbal Formulation

Required Fee: $56.00—Non-Refundable

(includes criminal records check fee)

Office Use Only:	
(CMH)	1421 - $35.00 2619 - $21.00

Office Use Only:

Check #_____

Amount:_____

Cash #_____

Lic. #_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

SECTION 1:
CURRENT MAINE ACUPUNCTURE LICENSE # EXP DATE:

☐ **Method #1: NCCAOM Certification with Chinese Herbology**

An official copy of the NCCAOM Certification in Oriental Medicine or Chinese Herbology must accompany this application.

☐ **Method #2: Education**

Check one: □ Master's Degree or □ Master's-level professional program in Oriental Medicine

Institution:

Address:

Degree Granted: Date Awarded:

At the time of completion was this institution:

☐ Accredited by ACAOM OR □ In candidacy for accreditation by ACAOM

☐ **Method #3: Herb Certificate Training Program**

Have you completed an herb certificate training program that consisted of a minimum of 450 hours of combined didactic instruction in herbs and herbal clinical training?

☐ YES ☐ NO

At the time of completion was this certificate training program:

☐ Accredited by ACAOM or ☐ In candidacy for accreditation by ACAOM

Name of Certificate Training Program:

Program Sponsor:

Address:

Date Certificate Awarded:

SECTION 2: NCCAOM CERTIFICATION:

Check one of the following:

☐ NCCAOM Certified in Oriental Medicine

☐ NCCAOM Certified in Chinese Herbology

You must submit a copy of the NCCAOM Certification

SECTION 3: LICENSE VERIFICATION

DO YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE? ☐ Yes ☐ No
If Yes, complete the following. Use a separate sheet of paper if necessary.

1. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

For each of the above, you must submit with this application an official Verification of Licensure from the licensing jurisdiction. IMPORTANT: Applications submitted without a Verification of Licensure from the licensing jurisdiction(s) for each of the above will not be accepted and your application returned as incomplete.

SECTION 4: CHECK APPROPRIATE RESPONSE TO THE QUESTION BELOW. ANY YES RESPONSE MUST BE FULLY EXPLAINED BY WRITTEN STATEMENT ON A SEPARATE SHEET OF PAPER, SIGNED AND DATED, AND SUBMITTED WITH YOUR APPLICATION.

Have you ever received a sanction from Medicare or from a state Medicaid program? 1. ☐ Medicare OR ☐ Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	☐ Yes ☐ No

SECTION 5: NOTICES

PLEASE NOTE - 10 Day Notification Requirement

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.
You can access this Law for your review at:
http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

SECTION 6: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be returned. This includes, but is not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Complementary Health Care Providers will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date